Quick Points

August 31, 2009

Information on submitting COB information electronically

Blue Cross and Blue Shield of Minnesota and Blue Plus have compiled a list of questions and answers in response to provider inquiries regarding the electronic submission of Coordination of Benefits (COB) information.

Questions and answers

1. **I understand that there is information on the HIPAA 835 transaction that I have to include on the electronic 837 COB transaction. Can you tell me what I have to include so I can make sure I get paid accurately?**

   It is important to use the Minnesota Uniform Companion Guides along with the HIPAA Implementation Guides to ensure the correct segments and elements are completed. The 2320, 2330A, 2330B, and the 2430 loops carry a good portion of the COB information a payer needs to process a secondary claim.

   The HIPAA 835 transaction provides most of the necessary information to complete the appropriate segments and elements.

   The HIPAA 835 transaction from the prior payer(s) should provide the CAS segments (loops 2100 and/or 2110), CLP segment (loop 2100), and the SVC segment (loop 2110) that are used to complete the 837 COB transaction.

2. **I understand the CAS segment is important for the correct processing of my COB 837 transaction. Where do I get the CAS segment information from?**

   Again, the CAS segment information on the 837 COB transaction should come directly from the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. This information must never be altered or combined in any manner.

3. **Do I need to do any combining of Claim Adjustment Reason Codes or change them to specific codes a Supplemental Insurer might want?**

   No, when completing the COB information on the 837 use the information as it was provided on the prior payer(s) HIPAA 835 or Remittance Advice/Explanation of Benefits. Never change or alter any of the prior payer(s) payment information including the Claim Adjustment Reason Codes (CARC), Claim Adjustment Group Codes, and Remittance Advice Remark Codes. Changing codes is a violation of HIPAA and could result in payment errors or processing delays. Per the HIPAA Implementation Guide, "**Codes and associated amounts should come from 835s (Remittance Advice) received on the claim.**" Payers utilize the codes to adjudicate based on the information sent.

Distribution: Due to the importance of this information this Quick Points is being mailed to all participating providers
QP20-09

4. **I know there are Medicare Primary claims that should have crossed over and Medicare has had some problems lately with not being able to cross claims over to supplemental payers. Should I send my all Medicare Primary COB claims just in case?**

   No, "automatic" rebilling often results in duplicate claims, increases administrative costs, and delays processing. Please go to **providers.bluecrossmn.com** and refer to our online Provider Policy and Procedure Manual, Chapter 8. This Chapter specifically references the procedures providers should use before sending a Medicare primary COB claim (see pages 8-31 through 8-33).

   If you check provider web self-service (PWSS) and the claim is not showing as crossed over 30 days after you received your Medicare payment, then you may submit the claim electronically with the COB information exactly as you received it on your Medicare ERA populated within the claim record.

5. **I have situations where my Medicare primary claims have been adjusted and Medicare is now paying on claims they have denied. How do I send these COB claims to my supplemental insurer?**

   These claims are COB adjustments to the original claim and should crossover to us directly from Medicare. Again, please go to **providers.bluecrossmn.com** and follow the online Provider Policy and Procedure Manual, Chapter 8. This Chapter specifically references the procedures providers should use before sending a Medicare primary COB claim (see pages 8-31 through 8-33).

   If the adjustment did not crossover as it should have within 30 days after you received the updated Medicare ERA, the procedures for submitting an adjustment/replacement claims until October 19, 2009, are outlined in our Provider Quick Points 13-09. Briefly, Providers should continue to request the claim changes as adjustments until October 19, 2009, using one of these methods:

   • Submitting a request through provider web self-service at **www.providerhub.com**
   • Fax in the *Provider Claim Adjustment/Status Check/Appeal Form* to **(651) 662-2745**
   • Mail in the *Provider Claim Adjustment/Status Check/Appeal Form* to:
     Blue Cross and Blue Shield of Minnesota
     P.O. Box 64560
     St. Paul, MN 55164-0560
   • Calling provider service at **(651) 662-5200** or **1-800-262-0820**

6. **I have a claim where Medicare paid first. They have now decided to pay one of the services on my three line claim. Should I just send in the COB claim for that one line for BCBS to pay the coinsurance and deductible?**

   No, never send a partial claim. This would be a violation of the rules in the Minnesota Uniform Companion Guides. Again, this could result in duplicate claims, increased administrative costs, and processing delays. If the prior payer has made a change to the original or prior claim processing outcome, the original or prior claim must be adjusted to ensure the secondary payment is correct. A "partial" claim should never be sent regardless of whether it is an original or adjustment. As noted in response to question #3 above, if the prior payer has adjudicated a claim with three services lines, all three service lines should be sent to the secondary payer. Never alter the charges and critical claim information when sending it to a secondary / tertiary payer for payment consideration.

7. **I have talked with other providers and they tell me that a COB claim must balance. What must balance?**

   The claim paid amounts must be equal to or greater than the line level paid amounts. The CAS segments must always reflect exactly what the prior payer has indicated on HIPAA 835 transaction or Remittance Advice/Explanation of Benefits. Do not add or combine the CAS information. Typically, the professional claim allowed and paid amounts should not be greater than the billed amounts. More information regarding balancing is available in the HIPAA Implementation Guides available for purchase from Washington Publishing (www.wpc-edi.com).

8. **When the prior payer is Medicare how do I list them as the primary payer? Do I list them by the Medicare Office, CMS, Federal Medicare, the name of the Medicare contractor, etc?**

   When Medicare is the prior payer, we suggest listing the prior payer as "Medicare."

9. **I am sending COB in the 837 transaction and also sending the EOB as an attachment with the report type code EB and report transmission code AA. This is to make sure that you get the COB information.**

   This specific issue was addressed in our July 29, 2009, Provider Quick Points (QP18-09). Specifically, in these situations, the Report of Transmission (PWK02) is AA indicating the EOB is available upon request at the provider office. The HIPAA 837 Implementation Guides, Report of Transmission (PWK Segment), states "The PWK segment is required if there is paper documentation supporting this claim. The PWK segment should not be used if the information related to the claim is being sent within the 837 ST-SE envelope."[1] Therefore sending the information within the transaction and also sending the PWK would be non-compliant and result in a rejection.

Questions?

If you have questions, please contact provider service at **(651) 662-5200** or **1-800-262-0820**.

[1] National Electronic Data Interchange Transaction Set Implementation Guide Health Care Claim: Professional 837 ASC X12N 837 (004010X098), Washington Publishing Company, May 2000, p. 214